DESCRIPTIVE AND PHENOMOLOGICAL STUDY OF CONDUCT DISORDER IN ELEMENTARY SCHOOL CHILDREN IN MYSORE DISTRICT

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CHAPTER - I

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

1.0 Mental Health Problems in Children

Schools play a crucial and formative role in all the dimensions - physical, cognitive, language, emotional, social and moral development of children. The school can contribute to mental health problems of children due to its formative influence both on normal and abnormal development. As almost all the young persons today face significant stresses in their lives, mental health and well being of them should be our greater concern. Evenly conservative estimates (Kapur, 1997) of 10 percent of the child population suffers from mental disturbances with serious associated impairmentals, including learning problems, health problems and drug abuse at any given time. It is also noticed that at least 3 percent of school-age children suffer from serious emotional disturbances such as severe depression and suicidal thoughts, psychoses, serious attentional problems or obsessive compulsive disorders. With nations moving towards a commitment to universalise education, there is a necessity for the schools to expand their roles by providing health services to handle the factors interfering with schooling.

Kapur (1997) gives the following suggestions for the school mental health programmes.

- Mental health programme should be part of a comprehensive health programme.
- It should include health instruction to teachers at all levels from primary to high schools.
- There should be easily accessible health services.
- A healthful, nurturing and safe environment and interaction with family and community organizations.
- The aim of school based intervention is to provide an experience that will strengthen children's coping abilities to counter the environmental stressors and disadvantages in their growing years.
- School-based intervention may be environment-centred or child-centred and one may lead to the other. An environment-centred programme may strive to enhance the ability of administrators, teachers and support staff to deal with specific kinds of behaviour and prepare them to make use of agencies serving children. Child-centred activities, on the other hand, deal with individual mental health problems, and focus on interventions as well as general classroom programme to improve coping skills.

From the above suggestions, it can be inferred that identification and understanding of the individual as well as his/her environment is essential to provide intervention relating to mental health problems.

Epidemiological studies of various sorts – descriptive, (study of the demographic characteristics and prevalence), phenomenological (detailed study using interview and various specially devised tool), aetiological (study of the bio-psycho social correlates of various disorders) and interventive epidemiology (service-oriented research, specially in school settings) are very much needed in Indian context for providing mental health services in the schools as an integral part of school education.

Kapur (1997) gave a summary of the trend of studies on mental health in India. Initially, single phase of screening was used. Later studies included a second phase of detailed investigation by using internationally standardized tools. Some of such tools are Rutter's Children's Behaviour Questionnaire (CBQT) for teachers, Reporting Questionnaire for Children (RQC) by Giel et al., Child Behaviour Checklist (CBCL) for parents, Teacher Report Form (TRF), Youth Self Report (YSR) by Achenbach and co-workers and Goldberg Health Questionnaire) (GHO). These tools are helpful for the detailed study of a child population for the study of phenomenology. For exploring the aetiological factors and to evaluate interventions different methodology and tools of assessment are required.

1.1 Nature of Conduct Disorder

Children and adolescents are frequently referred to mental health professionals because their behaviour is undesirable, inappropriate or out of control. Conduct disorder is one of the most expensive mental health problems, with significant financial expenditure incurred by a number of services, including education, the youth justice services and health. The emotional, social and physical costs to individuals and their families are also high. As they exhibit aggressive, disruptive and defiant behaviour, many children with conduct disorder create major difficulties and problems to teachers as well as society. Although their behaviour may evoke anger and outrage in others, many children with conduct problems are distressed and in need of help (Atkinson and Hornby, 2002). Since many teachers do not have the necessary support and training to cope with such pupils, there is an increasing probability that such children will be excluded from school. This further exacerbates their difficulties, creating a bigger and more long-term problem for society in general. Therefore it is highly important that teachers have a better understanding of these children's problems, develop the competencies to address their needs and that they utilize support from other agencies to help alleviate such difficulties.

DSM -IV (American Psychiatric Association, 1994) defines conduct disorder as a repetitive and persistent pattern of behaviour in which the rights of others or the rules of society are

violated. It involves at least three or more of fifteen criteria that fall into the following categories (Atkinson and Hornby, 2002).

Aggression including

- bullying, threatening or intimidating others
- initiating physical fights
- using a weapon that can cause serious harms to others.
- being physically cruel to animals
- stealing while confronting a victim
- forcing someone into sexual activity.

Destroying or losing of property, including

- deliberately engaging in fire setting with the intention of causing serious damage
- deliberately destroying others' properties.

Deceitfulness or theft, including

- breaking into some one else's house, building or car.
- lying to obtain goods or favours or to avoid obligations
- stealing items of value without confronting a victim

Serious violation of rules, including

- running away from home overnight (at least twice)
- playing truant from school (beginning before the age of 13).
- staying out all night without parental permission (beginning before the age of 13).

The criteria for conduct disorder in ICD-10 (World Health Organisation, 1992) are almost identical. Almost all children break the rules from time to time. But involvement in one or even a few incidents is insufficient for a child to be considered to have a conduct disorder. Only when conduct problems occur at school, at home and in the community, it indicates that the behaviour is not a response to the immediate social context.

Conduct problems can be mild, moderate or severe and they can include a diverse range of problems (Loeber et al. 2000). A distinction is also made between childhood onset conduct disorder, that is before the age of 10, and adolescent onset, the later one are associated with different presenting problems and a different course and outcome.

1.1.1 Salient features of Conduct Disorder

American Psychiatric Association (1994) has listed out the following salient features.

1. Central feature is the violation of the rights of others and the disregard for age appropriate social norms involving a very diverse range of behaviours.
2. Prominent characteristics are the non-compliance and aggression these children exhibit. Non compliance can take a variety of forms such as not doing what is asked, arguing, resistance or opposite of what is asked.

3. Defiance towards authority figures such as parents and teachers is common.
4. Relatively unrestrained aggression and low tolerance.
5. Among young children, temper tantrums are common.
6. Early signs of conduct disorder, often seen initially within the family, include disobedience, lying, stealing and aggression towards others. When the condition worsens this type of behaviour then extends outside the family into the school and the local community.
7. Though they project an image of toughness, their self-esteem is low.
8. Symptoms vary with age and with gender. There are two basic types of conduct disorder. Childhood onset, in contrast to adolescent onset, is associated with more serious and persistent antisocial behaviour. Males tend to express themselves in more overt ways, such as fighting and confrontation, whereas, females tend to express themselves in more covert ways, such as lying, truancy and running away from home. Suicide attempts are more common in girls with the disorder.

In addition to the above, Sommers - Flanagan and Sommers-Flanagan, (1998) observed the following features.

1. Children with conduct disorder also exhibits impulsiveness, poor peer relations and poor school performance.

2. Usually, they are not able to see the effects of their behaviour on others and they often have deficits in social skills.
3. They have little empathy and little concern for the feelings, wishes or well-being of others and have negative relationships with most people.
4. With parents and teachers difficulties tend to revolve around youngsters' defiant behaviour.
5. With peers main problem is aggression and bullying.
6. Peer rejection often leads to lack of self-esteem.
7. These children often lie about their problems, are sophisticated at manipulating others and avoid taking personal responsibility for their actions by blaming others (Kazdin, 1995).

Because of all the above features, parents often exhibit a sense of helplessness due to non-compliance leading parents as well as teachers, feeling frustrated and helpless. Parents often have marital, unemployment or psychiatric problems of their own and may have contact with a variety of helping agencies.

1.1.2 Differential Diagnosis and Associated Problems

More than two-thirds of children with conduct disorder also have oppositional defiant disorder (Hinshaw et al., 1993; Loeber et al., 2000). When present alone, this is only a mild disorder, which is less pervasive, where hostility and defiance, such as arguing, blaming others and vindictive behaviour are the central features.

Though it is not possible to understand the type of relationship, cases of conduct disorders are often preceded by oppositional defiant disorder (Webster Stratton and Herbert, 1994). However, adult antisocial personality disorder in which the individual shows no remorse for his/her activities can be preceded by conduct disorders in childhood.

Atkinson and Hornby (2002) noticed that there is a minority of school age children who lack guilt and seem heartless and who have a greater number of variety of problems, although they tend to be more intelligent than other children with conduct disorder. About a third to more than a half of children with conduct disorder also have attention deficit hyperactivity disorder (ADHD). This observation has been explained by (Nottleman and Jensen, 1995) in terms of a common underlying problem, such as impulsivity, although these disorders are considered as distinct from each other. Children with both tend to have more severe problems.

1.2 Incidence

Atkinson and Hornby (2002) reported the following on the basis of their epidemiological studies. Conduct disorder is the most frequently occurring of mental disorders affecting children and adolescents.

- Its incidence ranges from 6 to 16 percent in boys and from 2 to 9 percent in girls (American Psychiatric Association, 1994).
- Early persistent and severe patterns of antisocial conduct only occur in about 5 percent of children (Hinshaw and Anderson, 1996, Kazdin, 1995).

Conduct disorder is more prevalent during adolescence than childhood.

- The incidence of oppositional defiant disorder has consistently been found to be higher than conduct disorder and ranges from 10 to 22 percent of children (Nottleman and Junsen, 1995).
- The number of referrals for children with conduct disorders to all agencies is considered to be increasing.
- In childhood, conduct disorder is three or four times more common in boys, although this difference decreases by adolescence (Earls, 1994).
- In most boys onset occurs before the age of 10, whereas in most girls onset occurs between 13 and 16.
- There is greater persistence in boys than in girls, although many girls (between 1 and 6 percent) still display severe conduct problems as young adults.
- Conduct disorder is universal in that it occurs in every culture and level of society; however, different cultures

and societies may play different roles in its development and expression.

- Conduct disorder is found to be more prevalent in children and adolescents and from socially deprived backgrounds.

Davison and Neale (1994) emphasized that moral judgements are inherent in our conception of the disorder, for the very term conduct carries with it the connotation of good or bad. Moreover, since much of the behaviour considered as conduct problem has a high rate in the general population, a certain level of aggression or disobedience should probably be deemed normal. A survey of sixth-grade students in a middle-class suburb revealed that 26 percent had committed minor shoplifting, 22 percent had defaced property and 45 percent had fought with another student (Richards, Berk and Forster, 1979).

Davison and Neale (1994) therefore, recommends that many qualities of the child's behaviour itself must be considered in the diagnosis of conduct disorders. The two most important criteria for deciding whether a given act is aggressive or problematic are the frequency with which it occurs and the intensity of the behaviour (Herbert, 1978). These criteria of frequency and intensity do not fully solve the problem of defining conduct disorders, but they are important considerations. Because of the

definitional difficulties, the prevalence of conduct disorders is almost impossible to estimate accurately (Davison and Neale, 1994). However, they are quite common. In a population based study of more than 2500 children in Ontario, Canada, it was found out that 8 percent of boys and about 3 percent of girls aged four to sixteen met the DSM criteria for conduct disorder (Offord, Boyle, et al., 1987). Juvenile crime is a major problem particularly the more violent crimes of robbery and aggravated assault. The rate of juvenile crime increased greatly in the 1960s and 1970s and then leveled off at this higher frequency.

1.3 Causes of Conduct Disorder

There is a diverse range of potential influences on children's behaviour and this is likely to involve a complex interplay of child, family, community and cultural factors (Hester and Kaiser, 1998; Holmes et. al. 2001). Individual child characteristics, parenting practices and family organization are probably the most important factors which influence the likelihood of problems escalating into later life. Genetics and neurobiological factors may also play some part, as do also peer relationships and cultural and media influences, in the development of the disorder.

1.4 Intervention for Conduct Disorder

Children and adolescents with conduct disorder are likely to minimize their problems. Hence, information from others, particularly teachers and parents is crucial in assessing their difficulties (Kazdin, 1995). The most successful treatments address the pervasive nature of their difficulties and focus on the school, family and community context and children's social skills and academic deficiencies, as well as their behaviour.

Brosnan and Carr, 2000; Kazdin, 1997; Kazdin 2001 recommended the following as more promising treatments.

1. Behavioural Parental Training - Training parents in using specific behavioural skills
2. Family therapy - Focusing on communication, problem-solving and negotiation.
3. Multi-systematic therapy - The factors maintaining the problem, whether within the home, the child, the family, the school or the peer group are identified and interventions are developed.
4. Cognitive behaviour therapy- it is an individual form of treatment that enhances children's capacity to deal with conflict and teaches them to identify their thoughts, feelings and behaviours in problem solving situations.

5. Medication – A variety of medications have been used to treat conduct disorder, but medication alone is rarely sufficient to reduce aggressive behaviour.
6. Foster care treatment - In severe cases, individuals particularly adolescents will be benefited by this.

1.5 Context, Need and Importance of the Study

Loeber and Keenan (1994) noticed that most children and adolescents with conduct disorder have one or more other disorders. Oppositional defiant disorder and ADHD as well as depression and anxiety both occur more frequently in children with conduct disorder than in other children. it was observed by Harrington (1995) that about a third to a half has depression and about one-fifth to a half of those with conduct disorder experience anxiety. The presence of anxiety may inhibit aggressive behaviour but understanding of this relationship is limited. There are variations among individuals with conduct disorders of different age and gender as far as depression and anxiety are considered.

The presence of anxiety may inhibit aggressive behaviour but understanding of this relationship is limited.

Suicidal ideas, suicidal attempts and completed suicide are also found at a higher rate than normal in children with conduct disorders particularly in girls.

These children also tend to have lower than average intelligence, academic achievement below the expected level and often have associated learning difficulties.

Their non-compliance has direct implications for their learning at school. They have difficulty in following institutions.

Conduct disorders are also associated with risk-taking behaviour of various kinds, including early sexual activities, drinking, smoking and drug abuse, which can lead to expulsion from school, difficulties with the police or sexually transmitted diseases, etc. (Myers et al., 1993). This suggested that they often have other health-related problems. The rates of premature death are three to four times higher in boys with conduct disorder. The associated problems are severe, children may be able to live at home or to go to an ordinary mainstream school.

Treatment is easier in young children (Webster - Stratton and Herbert, 1996). Active involvement of parents leads to enhanced positive outcomes and a more long term effect. It is also important to assess the presence of other disorders since the treatment of other disorders, such as depression, anxiety, ADHD and substance abuse, may lead to reduction in conduct problems (Sommers - Flanagan and Somers - Flanagan, 1998)/

School has an important role to play in handling children with conduct disorders. Conduct disorders in children often create a lot of stress and suffering for everyone involved, which provides a strong argument for an emphasis on prevention, as do also the cost of society and the limited effectiveness of treatment (Offord and Bennet, 1994). Successful prevention includes

- early identification of children at risk (Holmes et. al., 2001),
- interventions in a range of contents, particularly in schools,
- arrangement of ongoing support for children and their parents (Hester and Keiser, 1998).

It is better, if preventive measures, focusing mainly on younger children who have not yet exhibited serious criminal or delinquent behaviours are undertaken. Once conduct disordered children or adolescents have come into contact with the juvenile system, it becomes much more difficult to redirect them to a prosocial way of life.

Since teachers are not trained in handling children/adolescents with conduct disorders in India, there is an immense need for studies and efforts in these directions.

1.6 Statement of the Problem

1.6.1 The Problem

Descriptive and phenomenological study of conduct disorders in children of elementary schools in Mysore district.

1.6.2 Specific Objectives

1. To identify the percentage of children with conduct disorder in Elementary Schools of Mysore district.
2. To understand the prevalence of the conduct disordered children of Mysore district in terms of demographic characteristics like type of schools (Govt. and private) grades (Pre school to VIII Std) and gender.
3. To determine the percentage of children exhibiting different types of conduct problems belonging to different groups based on type of schools, gender and grades.
4. To identify the associated problems like depression, anxiety, ADHD and academic difficulties in a few selected students.
5. To conduct a detailed study of the phenomenology of a few cases by interviewing parents by using Developmental Psychopatho pathology Checklist for children which assesses a) Developmental history, b) Developmental problems, c) Psychopathology, d) Temperamental profile and supportive factors for management.

1.6.3 Scope

The findings of the study help in understanding the salient features of children with conduct disorders in Indian context which in turn help in intervention and teacher training programmes. The study is mainly restricted to childhood conduct disorders.

CHAPTER - II

METHODOLOGY

2.0 Introduction

The details regarding sample tools and method of analysis are discussed in this Chapter.

2.1 Sample

For the purpose of identification and study of conduct disorders, 14 elementary schools were selected from Mysore District based on feasibility. However, due representation was given to Govt. and private schools as well as gender of the students. The study included children from pre-school through Grade VII. Tables 2.1 and 2.2 give the details of the sample.

Table 2.1 Description of the Sample

Sl. No.	School Code	Name of the School	Class	Total No. of Boys	Total No. of Girls	Total
1.	A.G	Govt. Girls Higher Primary School, Vontikoppal	I	12	12	24
			II	24	38	62
			III	17	14	31
			IV	8	11	19
			V	11	33	44
			VI	11	34	45
			VII	10	34	44
		Total		**93**	**176**	**269**
2.	B.G.	Govt. Boys Higher Primary School	I	26	30	56
			II	34	26	60
			III	27	27	54
			IV	20	28	48
			V	33	24	57
			VI	32	28	60
			VII	35	30	65
		Total		**207**	**193**	**400**

Sl. No.	School Code	Name of the School	Class	Total No. of Boys	Total No. of Girls	Total
3.	C.G.	Govt. Higher Primary School, Paduvarahally	I	8	13	21
			II	4	5	9
			III	10	12	22
			IV	9	7	16
			V	9	18	27
			VI	9	18	27
			VII	18	24	42
		Total		**58**	**106**	**164**
	D.G.	Kukkarahally School	I	11	10	21
			II	12	13	25
			III	16	18	34
			IV	23	29	52
			V	18	14	32
			VI	28	27	55
			VII	21	25	46
		Total		**129**	**136**	**265**
5.	E.G.	Govt. Tamil Higher Primary School, V.V. Road	I	5	5	10
			II	6	7	13
			III	5	6	11
			IV	7	12	19
			V	7	7	14
			VI	16	10	26
			VII	17	8	25
		Total		**63**	**55**	**118**
6	F.G.	Demonstration School	I	40	30	70
			II	37	34	71
			III	43	27	70
			IV	43	26	69
			V	40	30	70
			VI	39	31	70
			VII	38	31	69
		Total		**280**	**209**	**489**
7.	G.G	Govt. Higher Primary Boys School, Muguru	I	37		37
			II	32		32
			III	41		41
			IV	37		37
			V	33		33
			VI	65		65
			VII	65		65
		Total		**310**		**310**

Sl. No.	School Code	Name of the School	Class	Total No. of Boys	Total No. of Girls	Total
8.	H.G.	Govt. Higher Primary Girls School, Muguru	I		29	29
			II		50	50
			III		36	36
			IV		36	36
			V		53	53
			VI		69	69
			VII		54	54
		Total			**327**	**327**
9.	I.G.	Govt. Higher Primary and High School, K.Nagar	I	26	18	44
			II	35	24	59
			III	31	29	60
			IV	38	32	70
			V	45	36	81
			VI	57	44	101
			VII	90	51	141
		Total		**322**	**234**	**556**
10.	J.P.	Gangothri School	LKG	11	8	19
			UKG	6	13	19
			I	15	6	21
			II	19	5	24
			III	13	22	35
			IV	13	19	32
			V	21	20	41
			VI	22	20	42
			VII	38	27	65
		Total		**173**	**141**	**314**
11.	K.P.	Nirmala Convent	I	62	152	214
			II	55	141	196
			III	65	133	198
			IV	56	123	179
			V	71	128	199
			VI	69	152	221
			VII	73	137	210
			LKG	63	145	208
			UKG	76	155	231
		Total		**590**	**1266**	**1856**

Sl. No.	School Code	Name of the School	Class	Total No. of Boys	Total No. of Girls	Total
12.	L.P.	Pragathi Kendra School	I	32	22	54
			II	31	19	50
			III	17	15	32
			IV	7	10	17
			V	9	16	25
			VI	18	17	35
			VII	9	9	18
			VIII	11	9	20
		Total		**134**	**117**	**251**
13.	M.P	Govinda Rao Smaraka Jnana Vikasa Kendra	I	26	9	35
			II	16	13	29
			III	13	13	26
			IV	16	7	23
			V	15	10	25
			VI	14	8	22
			VII	16	5	21
		Total		**116**	**65**	**181**
14.	N.P	Royal English School	I	16	9	25
			II	22	10	32
			III	20	11	31
			IV	12	12	24
			V	8	9	17
			VI	8	9	17
			VII	22	7	29
		Total		108	67	175

Note : Sl. Nos. 1 to 9 indicate Government Schools and 10 to 14 private schools.

Table 2.2 Gradewise Distribution of the Sample

Grade	Pre-school	1	2	3	4	5	6	7	8
M	146	316	333	348	289	320	388	452	11
F	321	327	385	363	352	390	467	442	9
Total	**467**	**643**	**718**	**711**	**641**	**710**	**855**	**894**	**20**

From the above schools, the children with conduct disorders were identified with the help of behaviour schedule prepared by Ramaa, Ashok and Balachandra (1997) (vide Appendix I). The children who committed at least 3 symptoms and those who developed the problem before 10 years of age were only considered while identifying the children with conduct disorders.

CHAPTER - III

ANALYSIS

3.0 Introduction

The data collected in the study were analysed mainly through qualitative techniques. The details are discussed in this chapter.

3.1 Identification of Children with Conduct Disorders

The details regarding the number of children with conduct disorders are given in the table below.

Table 3.1 : Number of Children with Conduct Disorders

Total No. of Schools	Government			Private		
14	9			5		
	Boys	*Girls*	*Total*	*Boys*	*Girls*	*Total*
Total No. of Children (Pre-school to Grade VIII)	1555	1343	2898	1121	1522	2643
Percentage	53.65	46.34		42.41	57.58	
Number of CWCD*	43	10	53	39	2	40
Percentage of CWCD	2.76	0.7	1.82	3.4	0.12	1.51

Note : CWCD – Children with conduct disorders

The above table shows that 1.5 to 2% of children exhibited conduct disorder. The number of boys outnumber that of girls. The percentage of children exhibiting conduct disorders are more or less same in government and private schools.

The table below shows the gradewise distribution of CWCD in different schools. Since no children in preschool and grade VIII

exhibited atleast three characteristics of conduct disorders, none of them were identified as with the problem.

Table 3.2 : School and Gradewise Distribution of Children with Conduct Disorders

School Code	Grade	I		II		III		IV		V		VI		VII	
	Sex	M	F	M	F	M	F	M	F	M	F	M	F	M	F
AG		1	0	1	0	2	0	2	0	1	2	1	0	1	0
BG		0	0	0	0	0	0	0	0	1	0	1	0	1	0
CG		1	0	0	0	0	0	0	0	0	0	0	0	1	0
DG		0	0	0	0	0	1	3	0	2	0	2	4	1	0
EG		1	0	0	0	0	0	1	0	0	0	2	0	2	1
FG		1	0	1	1	2	1	1	0	5	0	0	0	0	0
GG		0	0	0	0	0	0	2	0	1	0	1	0	1	0
HG		0	0	0	0	0	0	0	0	0	0	0	0	0	0
IG		0	0	0	0	0	0	0	0	0	0	0	0	0	0
JP		3	0	3	0	0	0	1	0	0	0	1	0	0	0
KP		0	0	0	0	0	0	0	0	0	0	0	0	1	0
LP		2	0	3	1	0	0	0	0	6	0	3	0	8	0
MP		1	0	4	0	0	0	3	1	0	0	0	0	0	0
NP		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total No. of children with CWCD		10	0	12	2	4	2	13	1	16	2	11	4	16	1

The tables below give the gradewise distribution of children with conduct disorders and their percentage from Grades I through VII.

Table 3.3 : Percentage of Children with Conduct Disorders in Grade I

Male			Female			Total		
Total No. Of Children	No. of CWCD	Percentage Of CWCD	Total No. of Children	No. of CWCD	Percentage of CWCD	Total No. of Children	No. of CWCD	Percen-tage
316	10	3.2	327	0	0	643	10	1.5

Table 3.4 : Percentage of Children with Conduct Disorders in Grade II

Male			Female			Total		
Total No. Of Children	No. of CWCD	Percentage Of CWCD	Total No. of Children	No. of CWCD	Percentage of CWCD	Total No of Children	No. of CWCD	Percen-tage
333	12	3 6	385	2	0.5	718	14	1.9

Table 3.5 : Percentage of Children with Conduct Disorders in Grade III

Male			Female			Total		
Total No. Of Children	No. of CWCD	Percentage Of CWCD	Total No. of Children	No. of CWCD	Percentage of CWCD	Total No. of Children	No. of CWCD	Percen-tage
348	4	1.5	363	2	0.6	711	6	0.8

Table 3.6 : Percentage of Children with Conduct Disorders in Grade IV

Male			Female			Total		
Total No. Of Children	No. of CWCD	Percentage Of CWCD	Total No. of Children	No. of CWCD	Percentage of CWCD	Total No. of Children	No. of CWCD	Percen-tage
289	13	4.5	352	1	0.3	641	14	2.2

Table 3.7 : Percentage of Children with Conduct Disorders in Grade V

Male			Female			Total		
Total No. Of Children	No. of CWCD	Percentage Of CWCD	Total No. of Children	No. of CWCD	Percentage of CWCD	Total No. of Children	No. of CWCD	Percen-tage
320	16	5	390	2	0.5	710	18	2.5

Table 3.8 : Percentage of Children with Conduct Disorders in Grade VI

Male			Female			Total		
Total No. Of Children	No. of CWCD	Percentage Of CWCD	Total No of Children	No. of CWCD	Percentage of CWCD	Total No. of Children	No. of CWCD	Percen-tage
388	11	2.8	467	4	0.9	855	15	1.8

Table 3.9 : Percentage of Children with Conduct Disorders in Grade VII

Male			Female			Total		
Total No. Of Children	No of CWCD	Percentage Of CWCD	Total No. of Children	No. of CWCD	Percentage of CWCD	Total No. of Children	No. of CWCD	Percen-tage
452	16	3.5	442	1	0.2	894	17	1.9

From the tables 3.3 to 3.9, the following observations can be made.

a) The percentage of children with conduct disorders vary from 0.8 to 2.5 from grades I through VII.

b) In grades IV and V, the percentage of CWCD is relatively more than in the other grades.

c) In all the grades, the percentage of boys with CD are more compared to girls, in the ratio ranging from 3 : 1 to 12 : 1.

d) The percentage of boys with CD are more in grades IV and V compared to other grades, whereas in the case of girls, the variation in terms of percentage of CWCD is not considerable.

3.2 Frequency of CWCD demonstrating different types of conduct problems

In order to find out the number of children exhibiting the three types of conduct problems, namely, aggressive behaviour, deceitfulness and serious violation of rules, a gradewise and problemwise analysis of the data was done qualitatively. The table 3.10 gives the details of the same.

3.10 : Frequency of CWCD exhibiting different types of Conduct Problems

GRADE	Types of conduct problem		Aggressive behaviour				Deceitfulness		Serious violation of rules	
	Sex	Age	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absent) from school
1	M		6	1	8	2	1	4	0	1
	F		0	0	0	0	0	0	0	0
2	M		7	3	8	3	2	4	0	0
	F		2	0	1	0	0	1	0	1
3	M		2	2	2	1	0	0	0	1
	F		0	0	0	0	0	0	0	0
4	M		6	3	7	2	1	4	0	1
	F		0	0	0	0	0	0	0	0
5	M		14	5	12	2	0	6	0	0
	F		2	2	2	0	0	0	0	0
6	M		10	6	10	4	2	4	0	2
	F		4	2	4	0	0	4	0	0
7	M		14	5	10	2	1	3	1	2
	F		0	0	3	0	0	0	0	1
	Total No	M	59	24	57	16	7	25	1	7
		F	10	4	12	0	0	6	0	2

The above table shows clearly that the aggressive behaviours like bullying, teasing animals, initiating physical fights, use of weapons are more common problems exhibited by CWCD. However, the number of females exhibiting both these problem are considerably less compared to that of boys. Among the problems indicative of deceitfulness or theft, telling lie, is more common both among boys and girls. The frequency of children violating rules seriously are relatively less among CWCD at elementary school level.

3.3 School wise distribution of number of children exhibiting different symptoms of conduct disorders. Tables below give the details.

Table 3.11 : Frequency of Children exhibiting different Characters of Conduct Disorder in School (AG)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M	0	1	1	1	0	0	0	0
	F								
2	M	1	1	1	1	0	1	0	0
	F								
3	M	2	2	2	1	0	0	0	1
	F								
4	M	2	2	2	2	0	0	0	0
	F								
5	M	1	1	1	0	0	0	0	0
	F	2	2	2	0	0	0	0	0
6	M	1	1	1	1	0	0	1	1
	F								
7	M	1	1	1	1	0	0	0	0
	F								
Total of M&F		8+2	9+2	9+2	7+0	0+0	1+0	1+0	2+0
Total		10	11	11	7	0	1	1	2

Table 3.12 : Frequency of Children Exhibiting Different Symptoms of Conduct Disorder in School (BG)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
GRADE									
1	M								
	F								
2	M								
	F								
3	M								
	F								
4	M								
	F								
5	M	1	1	1					
	F					i			
6	M	1	1	1					
	F								
7	M	1	1	1	1	1	0	1	1
	F								
Total		3+0	3+0	3+0	1+0	1+0	0+0	1+0	1+0
		3	3	3	1	1	0	1	1

Table 3.13 : Frequency Of Children Exhibiting Different Symptoms of Conduct disorder in School (CG)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
GRADE									
1	M	1	1	1	1	1	1	0	0
	F								
2	M								
	F								
3	M								
	F								
4	M								
	F								
5	M								
	F								
6	M								
	F								
7	M	1	1	1	0	0	1	0	0
	F								0+0
Total of M & F		2+0	2+0	2+0	1+0	1+0	2+0	0+0	
		2	2	2	1	1	2	0	0

3.14 : Frequency of Children Exhibiting Different Symptoms of Conduct Disorders in School (DG)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M								
	F								
2	M								
	F								
3	M								
	F	1	0	1	0	0	1	0	0
4	M	3	0	3	0	0	3	0	0
	F								
5	M	2	0	2	0	0	2	0	0
	F								
6	M	2	0	2	0	0	2	0	0
	F	4	0	4	0	0	4	0	0
7	M	0	0	0	0	0	0	0	1
	F								
Total of M & F		11+1	0+0	11+1	0+0	0+0	11+1	0+0	1+0
Grand Total		12	0	12	0	0	12	0	1

3.15 Frequency of Children Exhibiting Different Symptoms of Conduct Disorders in School (EG)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M	0	0	1	0	0	0	0	0
	F								
2	M								
	F								
3	M								
	F								
4	M	0	0	1	0	0	0	0	0
	F								
5	M								
	F								
6	M	2	0	2	0	0	2	0	1
	F								
7	M	2	1	2	0	0	0	0	0
	F								1
Total of M & F		4+0	1+0	6+0	0+0	0+0	2+0	0+0	2+1
Grand Total		4	1	6	0	0	2	0	3

3.16 Frequency of Children exhibiting different symptoms of conduct disorders in School (FG)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M	0							
	F								
2	M	0	0	1	0	0	0	0	0
	F	1	0	0	0	0	0	0	0
3	M								
	F	1	0	0	0	0	0	0	0
4	M	0	0	1	0	1	0	0	0
	F								
5	M	4	0	5	0	0	2	0	0
	F								
6	M								
	F								
7	M								
	F								
		4+2	0+0	7+0	0+0	1+0	2+0	0+0	1+0
Total		6	0	7	0	1	2	0	1

3.17 Frequency of Children Exhibiting Different Symptoms of Conduct Disorders in School (GP)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M	3	0	3	0	0	3	0	0
	F								
2	M	2	0	3	0	0	0	0	0
	F								
3	M	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	0	0
4	M	1	1	0	0	0	1	0	0
	F								
5	M								
	F								
6	M	1	0	1			1	0	0
	F								
7	M						0	0	0
	F								

3.18 Frequency of Children Exhibiting Different Symptoms of Conduct Disorders in School (HP)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M								
	F								
2	M								
	F								
3	M								
	F								
4	M								
	F								
5	M								
	F								
6	M								
	F								
7	M	1	1	1	0	0	1	0	0
	F								
		1+0	1+0	1+0	0+0	0+0	1+0	0+0	0+0
		1	1	1	0	0	1	0	0

3.19 Frequency of Children Exhibiting Different Symptoms of Conduct Disorders in School (IP)

Type of Conduct Disorder		Aggression				Deceit fullness		Serious Violation of rules	
GRADE	Sex	Often bullies threatens or intimidates other	Has been cruel to animals and or people	Often initiates physical fights with others	Used weapon that can cause serious physical harm to others (Eg. A bat, brick broken bottle knife	Often steals at home	Often lies to obtain good or favour or to avoid obligation (the work that ought to be done)	Run away from home at least twice while living with parents or parental surrogates	Often truant (absents) from school
1	M	2	0	2	0	0	1	0	0
	F								
2	M	3	0	3	2	1	3	0	0
	F	1	0	1	0	0	1	0	1
3	M								
	F								
4	M								
	F								
5	M	6	3	5	2	0	2	0	0
	F								
6	M	3	2	3	3	1	1	0	0
	F								
7	M	8	0	4	0	0	0	0	0
	F								

From the above tables, the following observations can be made.

a) Out of 14 schools, 5 schools did not report CD in any child.

b) The number of children exhibiting different characteristics vary widely from school to school.

c) Out of nine schools only in one of the government schools, all the grades had CWCD whereas five schools had CWCD in many grades and in the remaining three schools, CD were exhibited in children of one or two grades.

d) Out of the three categories of CD namely Aggression, Deceitfulness and Serious Violation of rules, more number of children exhibited aggressive behaviours and least number of children exhibited serious violation of rules.

e) Out of the four characteristics of aggression, two characters viz. bullying/threatening and intimidating others are more common.

f) Under the category of deceitfulness, telling lies appears to be more common compared to stealing.

g) Truant from schools are slightly more common than that of running away from home among CWCD.

3.4.1 *Phenomenological Study of the CWCD*

Out of the 93 cases identified as CWCD, from the 14 school, included in the study, two students with moderate to severe level of CD were studied in detail by using the Ten sub scales of Child Behaviour Checklist (CBCL) (Achenbach, 1991a) and Developmental Psychopathology Checklist for children (Kapur, 1997). In addition to

them, one more student, who is confirmed to have moderate level of conduct disorder and studying in X Grade was also studied. The data were collected in detail by using the same tools by interviewing the parents of those children.

The tool along with the data collected from the interview are in Appendix A, B and C respectively.

The cases exhibited various other kinds of behaviours as depicted in the interview along with specific behaviour of conduct disorders.

3.4.1 Associated problems in Case 1

(i) **Identification Data**

Name : S.S.

Sex : Male

Grade : VII

Date of Birth : 19.7.1991

Father's Education : Ph.D.

Mother's Education : Graduation

Mother Tongue : Telugu

Informant : Father

(ii) **Problems noticed by using the ten sub scales of CBCL**

1. Hyperactivity
2. Aggressive behaviour
3. Tendency towards Delinquency

(iii) Problems observed through developmental psycopathology checklist for children

1. Developmental history : Did not indicate any problem.
2. Developmental Problem :

   Currently or in the past has there been a problem of :

   - only one problem - dropping things, falling or tripling frequently.
3. Psychopathology - The following problems are present :

   a) Hyperkinesis

   b) Conduct disorder

4. Psychological - there is evidence of psychosocial stressors.
5. Temperamental profile - Nature or Temperament of child

   a) Psychosocial aspects

      i) Difficult to manage

      ii) Not independent

   b) Biosocial aspects

      i) too much of activity

      ii) Too little persistence

3.4.2 Associated problems in Case 2 :

(i) Identification Data

Name : R R

Sex : M

Grade : X

Age : 15 years

Father's Education : Graduation

Mother's Education : PUC

Informant : Mother

(ii) Problems noticed through CBCL

1. Hyperactivity
2. Aggressive behaviour
3. Tendency towards Delinquency
4. Even now treated for bed wetting
5. Nail biting

(iii) Problems observed through developmental psychopathology checklist for children

1. Developmental history
   a) Suffered from jaundice
   b) Epilepsy at 1 ½ years
2. Developmental problem - no indication
3. Psychopathology
   a) Hyperkinesis
   b) Conduct disorder
   c) Learning problem
4. Psychological - There are indications of psychosocial stressors.

Temperamental profile

Psychosocial aspects

a) Difficult to manage

b) Not independent

c) Not dependable

Biosocial aspects

a) Angry – intensively

b) Tense

Too little persistence.

Not sociable with family members.

Variable in sociability with others.

Mostly aggressive – verbally and physically.

3.4.3 Associated Problems in Case 3 :

(i) Identification Data

Name : S.H.

Sex : M

Grade : IX

Age : 14 years

Father's Education : L.LB.

Mother's Education : PUC

Informants : Father and Mother

(ii) Problems noticed through CBCL

1. Hyperactivity
2. Aggressive
3. Tendency towards Delinquency
4. Lacks guilt
5. Prefers older children

(iii) Problems observed through developmental psychopathology checklist for children.

1. Developmental history - No indication of any problem.
2. Developmental problems - No indication.
3. Psychopathology
   - i) Hyperkinesis
   - ii) Conduct disorder
   - iii) Learning problems
4. Psychological
   - i) Psychosocial factors are indicated.
   - ii) Temperamental
     - Psychosocial aspects
       - (a) Difficult to manage
       - (b) Not dependable
       - (c) Not sensitive to others' emotions.
       - (d) No moral discrimination
       - (e) Not trustworthy

3.5 Major Findings and Discussion

Major findings are discussed below :

1. About 1.5 to 2% children studying in grades pre-school through VIII exhibited conduct disorder. This figure is considerably lower in India, in comparison with other countries (vide 1.2 for details).
2. The number of boys with conduct disorders outnumber that of girls. This finding is similar to the observation made by Earls, (1994) that childhood conduct disorder is three to four times more common in boys.
3. The number of children with CD is more or less same in government and private school.
4. The percentage of children with CD vary from grade to grade ranging from 0.8 to 2.5. The percentage of CWCD is relatively more in grades VI and V particularly among boys.
5. The percentage of boys with CD are more compared to that of girls in all the grades ranging in the ratio of 3 : 1 to 12 : 1.
6. Among the three main categories of conduct disorders (Atkinson and Hornby, 2002), aggressiveness, deceitfulness and serious violation of rules assessed in the study, more number of children both boys and girls exhibited aggressiveness followed by deceitfulness and serious violation of rules. This observation is slightly different from that of the American Psychiatric Association (1994). They noticed that males tend to express themselves more

overt ways whereas females tend to express themselves more covert ways such as lying, truancy and running away.

7. In the study, it was noticed that children exhibited conduct problems of mild, moderate and several levels. They exhibited diverse range of problems. This finding is supporting the observation made by Lober et al (2000).

8. The phenomenological study of all the three cases studied in detail indicated the following :

   a) As revealed in CBCL, two children exhibited hyper activity, aggressive behaviour and tendency towards delinquency whereas one case (SH) exhibited lack of guilt, preferring older children in addition to the above mentioned three problems. This finding is similar to that of Nottleman and Jensen (1995) and Atkinson and Hornby (2002) who tried to explain these problems in terms of a common underlying problem such as impulsivity.

   b) Two cases did not show any history of developmental problem, one case (RR) suffered from jaundice and epilepsy during early childhood.

   c) Two cases (RR & SH) exhibited learning problems.

   d) In all the cases psychosocial stressors were present.

   e) All the three cases posed challenge to parents to manage them in the past as well as in the present. They also exhibited temperamental characteristics. Psychosocial aspects of temperament like - not independent, not

dependable. In addition to that, one case (SH) exhibited the characters like - not sensitive to others' emotions, no moral discrimination, not trust worthy. This supports the finding of Atkinson & Hornby (2002) that there is a minority of school age children who lack guilt and seem heartless and have greater number of variety of problems. As far as biosocial factors of temperament is concerned, two children exhibited different types of problems like - too much of activity, too little persistence, intensive anger (verbal and physical), pronounced tension, not sociable with family members, variability in sociability with others.

3.6 Conclusion and Recommendations

On the basis of the major findings of the study, following conclusions can be drawn tentatively and some recommendations can be made for the improvement of overall quality of education which in turn can prevent/correct conduct disorders.

Conduct disorder is one of the most expensive mental health problem. It incurs significant cost by a number of services. The emotional, social and physical costs to individuals and their families are also high. Anti social behaviour appears to be a growing problem requiring urgent attention.

Since there are children with various kinds of conduct problems corrective measures have to be taken by involving multidisciplinary team.

For the success of any program to help children with conduct disorder, coordination of family, school and community is required.

Early identification is crucial , owing to the seriousness of the problem, at the later years of life.

Identifying the cause of the behaviour is helpful to treat the problem.

Preventive measures must be taken at early childhood stage, to check onset of conduct disorder at primary school stage.

Mental health programmes have to be implemented in all the schools. role of counsellors have to be emphasized and provision for appointing guidance counselors for a cluster of schools is important.

Associated problems like ADHD, depression, anxiety and others also should be kept in mind while planning intervention programme for these children.

It is in the hands of teachers/schools/community to plan preventive measures focusing mainly on younger children (suspects of CD) who still have not exhibited serious criminal or delinquent behaviour and direct them to a prosocial way of life.

Conducive socio-emotional climate is essential in the schools. Teachers should follow professional ethics adequately. Various co-curricular activities which inculcate universal ethical values among children have to be conducted in the schools for all the children. Children with CD should be made to involve in all such activities. Emphasis should be given for the practice of values in day to day situation.

In the case of children from pathological families, where parents/guardians cannot adopt good child rearing practices educational placement in a residential set up is necessary. The residential schools should prevent conduct problems by taking proper measures. Incentives can be introduced for desirable behaviour among children in schools. Academic performance of children with conduct disorders should also be improved.

Teacher training programmes should include the intervention of conduct disorders. More number of studies relating to conduct disorders both among children and adolescents have to be conducted.

The Child Behaviour Checklist (CBCL) (Achenbach 1991a) which was used in the study is used by parents to rate the behaviour competencies and behaviour problems of their child. This has to be used in connection with the CBCL (Achenbach 1991b). The latter gives child behaviour profile for ages 4 - 18 which provides the interpretive guidelines for the information obtained from the CBCL. There is also a need to use supplemental instruments or components like teacher report form cum direct observation form and a youth self report (Taylor 2000).

The emotional and social characteristics that people exhibit are the result of experiences they have had with others throughout their lives and are an accumulation of thoughts, feelings, attitudes and skills; this is especially true of teachers and students in the classroom environment (Henson and Eller, 1999). So classroom environment should be conducive to proper emotional and social development.

It is highly essential to train children with Conduct Disorder in social cognition, social problem solving and social skills which are critical factors. In addition to learning academic subjects, the teacher also has to learn from the social environment of the classroom. As part of their decision making role, teachers should make efforts to incorporate the training of social cognition into daily classroom activities and recognize that cognitive learning and affective learning are inseparable.

The social environment of the classroom has to be arranged in such a way that it encourages the student to interact with each other, ask questions, and challenge ideas. (Nucci and Gordon, 1979). Additional opportunities for students should also be allowed to discuss their feelings and learn about the feelings of others. Many programmes and models of teaching social skills have been developed by Oden (1986) and Cartledge & Milburn (1986).

Similar programmes and models of teaching social skills have to be developed in Indian context also.

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S. S[redacted] (M).

7th A

19.7.1991

F - PhD

M - Graduate.

Tamil.

Father's perception.

Prob - Above Av.

KV 4th. 6th.

Reacts to others bully, gets caught & teachers complain.

Because father complained to Princi teachers snub him

V. V. interested in play.

[redacted] Other boys created

Not able to conc.

Normal as a child

before going to school, he used to run & play a lot

Not much on board games

Appendix A

Ten Subscales of Child Behaviour Checklist

The CBCL items were grouped under ten subscales as follows:

I. Schizoid or Anxious

- Clings to adults
- Fears
- Fears school
- Hears things that aren't there
- Nightmares
- Anxious
- Sees things that aren't there
- Shy, timid

II. Depressed

- Lonely
- Cries much
- Harms self
- Fears own impulses
- Needs to be perfect

Feels unloved
Feels persecuted
Feels worthless
Nervous
Anxious
Feels guilty
Self-conscious
Sulks
Suspicious
Suicial talk
Sad
Worrying

III. Uncommunicative

Confused
Won't talk
Secretive
Self-conscious
Shy, timid
Stares blankly
Stubborn
Sad

IV. Obsessive-Compulsive

Obsessions
Confused
Daydreams
Twitches
Nightmares

Anxious
Overtired
Compulsions
Sleeps little
Stares blankly
Hoarding
Strange behaviour
Strange ideas
Walks, talks in sleep
Excess talk
Can't sleep

V. Somatic Complaints

Constipated
Dizziness
Overtired
Pains
Much sleep

VI. Social Withdrawal

Poor peer relations
Feels persecuted
Is teased
Likes to be alone
Unliked
Prefers young children
Slow moving
Withdrawn

VII. Hyperactive

- Acts too young ✓ plays with younger brother
- Can't concentrate ✓
- Hyperactive ✓ since LKG & complaint
- Confused ✓
- Daydreams ✗
- Destroys own things ✗ careless
- Impulsive ✓
- Poor school work ✗
- Clumsy ✗
- Prefers young children ✗
- Speech problems ✗

VIII. Aggressive

- Argues ✓ with parents & peers only never with teachers
- Brags ✗
- Cruel to others ✗
- Demands attention ✗
- Disobeys at home ✗
- Disobeys at school ✗
- Poor peer relations ✗
- Jealous ✗
- Fights ✗
- Lies, cheats ✓
- Unliked ✗
- Attacks people ✗
- Screams ✗
- Shows off ✓

- Stubborn ✗
- Moody ✗
- Sulks ✗
- Swearing ✗ Demands if has to sit for studies.
- Excess talk ✓
- Teases ✓ (not to the extent of hurting
- Temper tantrums ✗
- Threatens ✗
- Loud ✗

IX. Delinquent

- Destroys own things ✗
- Destroys others' things ✗
- Disobeys at school ✗
- Bad friends ✓ Can't distinguish good & bad & becomes friendly with bad
- Lies, cheats ✓
- Runs away ✗
- Sets fires ✗
- Steals at home ✗
- Steals outside home ✗
- Swearing ✗
- Truant ✗
- Vandalism ✗

X. Other Problems

- Allergy ✗
- Asthma ✗
- Acts like opposite sex ✗
- Encopresis ✗

Cruel to animals X
Doesn't eat well X
Lacks guilt X
Eats nonfood X
Accident prone X
Nailbiting X
Overeats X
Overweight X
Physical problems — Lost all teeth when 3 yr old — fell. - Problem began with this trs & peers started teasing him
Picking nose X
Prefers older children X
Sex problems X
Smears bowel X
Thumbsucking X
Too neat X
Alcohol, drug X
Wets self X
Wets bed X
Whining
Wishes to be opposite sex X
Other problems

—

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Appendix-2

DEVELOPMENTAL PSYCHOPATHOLOGY CHECK LIST FOR CHILDREN

(A)	DEVELOPMENTAL HISTORY	Yes	No
1	Did the mother, before, during or just after childbirth suffer from any problems like illness or difficult labour.	0	1
2.	Did the child have any serious illness soon after birth. (If yes, specify)	0	1
3.	Has the child had epilepsy, head injury, infections or any other serious illness? (If yes, specify.)	0	1
4.	Has the child any problems in seeing? (If yes, describe.)	0	1
5.	Has the child any problems in hearing? (If yes, describe)	0	1
6.	Between the ages of 1 and 3, could the child walk, climb, throw a ball? (If not, mark as present)	0	1
7.	Could the child by the age of 3, cut paper, thread beads (If not, mark as present.)	0	1
8	Between the ages of 1 and 3, could the child speak in small sentences? (If not, mark as present.)	0	1
9	Could the child between the age of 1 and 3 years show appropriate emotional expression in relation to parents and others and did he/she enjoy playing with other children. (If not, mark as present)	0	1

10.	Could the child between the age of 3 and 5 years, feed, wash and dress him/herself? (If not, mark as present.)	0	1

(B) DEVELOPMENTAL PROBLEMS

	Currently or in the past, has there been a problem:		
11.	of dropping things, falling or tripping frequently.	0	1
12.	for brief period when the child cried continuously to the extent of holding breath, become stiff, and turning blue in the face.	0	1
13.	of making odd or funny, repeated movements of the face, body, arms and legs	0	1
14	in pronouncing words clearly (for example: 'Labbit' for 'Rabbit').	0	1
15.	in speaking, as stammering or stuttering.	0	1
	Currently, does the child have the problems of:		
16.	not talking at all and remaining mute, despite knowing how to speak, in some situations and to some people.	0	1
17.	repeating the words spoken by others exactly in the manner they were heard, without appearing to understand the meaning.	0	1
18.	appearing to understand what is being said but seemingly not being able to answer.	0	1
19.	of not being able to understand what is being spoken.	0	1
20.	appearing to understand and knowing how to speak, but speaking in a manner which other people find difficult to understand, and refusing to use gestures to convey his/her needs.	0	1
21.	not being able to relate to people.	0	1
22.	not being able to play with other children.	0	1
23.	feeding such as overeating, undereating, food fads or fussy eating habits, and eating non-edible things such as mud (If present, specify.)	0	1
24.	wetting clothes or bed from a very early age.	0	1
25.	resuming wetting of the clothes or bed, after being dry earlier on.	0	1

26.	of soiling of the clothes with stools, or has constipation. (If present, specify.)	0	1
27.	sleeping such as sleep-walking, sleep-talking, teeth-grinding, nightmares, etc. (If present, specify.)	0	1
28.	masturbating or any other sexual problems (which are indulged in public).	0	1

(C) PSYCHOPATHOLOGY

(The items below are marked as being present *only* when they occur *often or most of the time* but not when they occur sometimes)

	Does the child have the problems of:		
29.	poor attention	0	1
30.	distractability—(if the child is doing a task and someone enters the room, or he hears a sound, does he easily get distracted by this).	0	1
31	inability to sit in a place, and always moving around	0	1
32.	acting without thinking, like while crossing the road not looking out for the traffic.	0	1
33	stubbornness.	0	1
34.	disobedience.	0	1
35.	often interrupting others' games, talk; being disruptive while playing, or breaking/throwing things frequently.	0	1
36	quarrelsomeness and fighting.	0	1
37.	aggression as seen by hitting, biting and pinching others (with/without provocation).	0	1
38.	getting very angry, crying a lot, rolling on the ground and continuing to be so for a long time, when his/her demands are not met.	0	1
39.	going to school and coming back on time, but actually does not attend the school.	0	1
40.	indulging in lying and cheating.	0	1
41.	refusing to go to school and staying back home for a duration of weeks or months.	0	1
42.	poor school performance.	0	1
43.	reading difficulty.	0	1
44.	difficulty in writing.	0	1

45.	difficulty in arithmetic.	0	1
46.	forgetfulness or poor memory.	0	1
47.	day-dreaming.	0	1
48.	being very quiet and reserved (withdrawn).	0	1
49.	talking very little even with family members.	0	1
50.	worrying.	0	1
51.	anxiousness and nervousness	0	1
52.	shyness and timidity	0	1
53.	fear of animals/people/situations	0	1
54.	clinging.	0	1
55.	crying easily.	0	1
56.	going on doing a particular thing over and over again, such as washing hands, or repeatedly saying certain numbers, or expressing that certain thoughts come to his/her mind repeatedly to the extent that they interfere with his/her daily activities.	0	1
57.	complaining of dizziness or giddiness.	0	1
58.	complaining of aches and pains.	0	1
59.	complaining of/or appearing to be always tired.	0	1
60.	complaining of stomachache.	0	1
61.	fainting spells.	0	1
62.	attacks of jerky movements and unconsciousness (fits, conversions to be differentiated from epilepsy by a clinician).	0	1
63.	complaining of pulling sensation of the limbs.	0	1
64.	chronic physical illness. (Specify, if present.)	0	1
65.	physical handicaps. (Specify, if present.)	0	1

Currently or in the past, has there been a problem of:

(The items below are to be marked as present *even* it has occurred *more than once in the past or present*).

66.	hearing voices and seeing things when no one was around.	0	1
67.	maintaining postures, being stiff, over long periods of time. (If present, describe.)	0	1
68.	saying that he/she was a great person, or a bad person, or that he/she was being harmed by other people without real basis for such beliefs.	0	1

69.	talking and laughing to self.	0	1
70.	very poor appetite, sometimes leading to loss of weight.	0	1
71.	poor sleep/disturbed sleep.	0	1
72.	wetting and soiling during illness and was unaware of it.	0	1
73.	loss of interest in play and daily activities.	0	1
74.	moving and responding unusually slowly.	0	1
75.	being depressed, sad and dull.	0	1
76.	talking much more or faster than he/she normally used to.	0	1
77.	being irritable.	0	1
78.	being unusually cheerful and happy. (Others, if any)	0	1

(D) PSYCHOSOCIAL FACTORS

(The items below are to be marked as present, whether in the past or present.)

Family history of:

79.	anyone having mental illness.	0	1
80.	anyone taking alcohol excessively.	0	1
81.	anyone having epilepsy.	0	1
82.	anyone having problems in reading, writing or arithmetic.	0	1
83.	anyone having bed-wetting	0	1
84	anyone having speech problems.	0	1
85.	anyone being very dull or mentally retarded	0	1
86.	Have there been any precipitating events at the time of onset of the problems. (Specify, if present.)	0	1

Interaction in the Family

Is there any evidence of:

87.	problems with parents. (If present, describe)	0	1
88.	sibling rivalry (jealousy of brothers and sisters).	0	1
89.	marital disharmony (parents fight a lot).	0	1
90.	punitiveness: Parents frequently resort to hitting, beating or punishing the child.	0	1

91	overexpectations: Parents expect from the child beyond his abilities, especially in school performance.	0	1
92.	overinvolvement: Parents are involved with all the child's activities to the extent that he/she does not do anything on his/her own.	0	1
93.	overindulgence: Parents meet all the demands of the child, whether reasonable or not.	0	1
94.	indifference: Parents are not bothered about the child's physical or psychological needs	0	1
95.	inconsistent disciplining: Parents do not agree about the way to discipline the child.	0	1
96.	multiple caretaking: (The child is brought up by a number of adults in the family).	0	1
97.	single parent: The child has been cared for by a single parent.	0	1
98.	any change of school, medium or specific subjects or teachers.	0	1
99.	the child complaining of problems with teachers.	0	1
100.	the child having problems in playing, mixing or socializing with other children	0	1
101.	the child having problems such as poverty and other stressors, not covered in the above section (if present, specify).	0	1

(E) TEMPERAMENTAL PROFILE

Descriptions of some aspects of the child's nature or temperament are given, and each description has three options to choose from. Encircle the options which fits the child best. If the description is not applicable, if may be mentioned, especially for younger children.

Temperamental dimensions:

(a) *Psychosocial:*

								Not applicable
102.	Easy to manage	mostly	0	somewhat	1	not at all	1	..
103.	Independent (can manage himself/herself)	mostly	0	somewhat	1	not at all	1	..
104.	Dependable	mostly	0	somewhat	1	not at all	1	..
105.	Sensitive (to other peoples' needs, emotions)	mostly	0	somewhat	1	not at all	1	..
106.	Sensitive (only about oneself)	mostly	0	somewhat	1	not at all	1	..
107.	Trusting	mostly	0	somewhat	1	not at all	1	..
108.	Trustworthy	mostly	0	somewhat	1	not at all	1	..
109.	Moral (discriminates between good & bad, knows it's bad to hit others, steal, etc.)	mostly	0	somewhat	1	not at all	1	..

(b) *Biosocial*

110.	Sleep pattern	moderate	0	too little	1	too much	1	.
111.	Appetite	moderate	0	too little	1	too much	1	..
112.	Activity	moderate	0	too little	1	too much	1	.
113.	Emotionally	cheerful (stable)	0	angry/tense (intense & variable)	1	dull (non reactive)	1	..
114.	Persistence	good	0	variable	1	too little	1	..
115.	Sociability with family members	mostly	0	variable	1	not at all	1	..

116.	Sociability with others	mostly	0	variable	1	not at all	1	..
117.	Aggressive (verbal)	not at all	0	mostly	1	somewhat	1	
118.	Aggressive (physical)	not at all	0	mostly	1	somewhat	1	

..

(F) SUPPORTIVE FACTORS FOR MANAGEMENT

119.	Does the child have any helpful person at home/outside: Somebody to whom the child is attached to, who helps the child, takes him/her out, buys the child gifts? (If yes, describe.)	0	1
120.	Does the child have friends in the neighbourhood or school? (If yes, describe.)	0	1
121.	Does the child have interest in drawing, painting, games, music, etc? (If yes, describe.)	0	1
122.	Does the child have any special talents? (If yes, describe)	0	1
123.	Is the child good at sports? (If present, describe.)	0	1
124.	Is the child creative, can put together commonplace objects in a new fashion, or make objects with hands? (If present, describe.)	0	1

Other observations, if any:

SUMMARY

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15 years
X Std
Middle class family

Appendix B

Ten Subscales of Child Behaviour Checklist

The CBCL items were grouped under ten subscales as follows

I. Schizoid or Anxious

- Clings to adults
- Fears
- Fears school
- Hears things that aren't there
- Nightmares
- Anxious
- Sees things that aren't there
- Shy, timid

II. Depressed

- Lonely
- Cries much
- Harms self
- Fears own impulses
- Needs to be perfect

Feels unloved
Feels persecuted
Feels worthless
Nervous
Anxious
Feels guilty
Self-conscious
Sulks
Suspicious
Suicial talk
Sad
Worrying

III. Uncommunicative

Confused
Won't talk
Secretive
Self-conscious
Shy, timid
Stares blankly
Stubborn
Sad

IV. Obsessive-Compulsive

Obsessions
Confused
Daydreams
Twitches
Nightmares

Anxious
Overtired
Compulsions
Sleeps little
Stares blankly
Hoarding
Strange behaviour
Strange ideas
Walks, talks in sleep
Excess talk
Can't sleep

V. Somatic Complaints

Constipated
Dizziness
Overtired
Pains
Much sleep

VI. Social Withdrawal

Poor peer relations
Feels persecuted
Is teased
Likes to be alone
Unliked
Prefers young children
Slow moving
Withdrawn

VII. Hyperactive

- Acts too young
- Can't concentrate
- Hyperactive
- Confused
- Daydreams
- Destroys own things
- Impulsive
- Poor school work
- Clumsy
- Prefers young children
- Speech problems

VIII. Aggressive

- Argues
- Brags
- Cruel to others
- Demands attention
- Disobeys at home
- Disobeys at school
- Poor peer relations
- Jealous
- Fights
- Lies, cheats
- Unliked
- Attacks people
- Screams
- Shows off

- Stubborn
- Moody
- Sulks
- Swearing
- Excess talk
- Teases
- Temper tantrums
- Threatens
- Loud

IX. Delinquent

- Destroys own things
- Destroys others' things
- Disobeys at school
- Bad friends
- Lies, cheats
- Runs away
- Sets fires
- Steals at home
- Steals outside home
- Swearing
- Truant
- Vandalism

X. Other Problems

- Allergy
- Asthma
- Acts like opposite sex
- Encopresis

Cruel to animals
Doesn't eat well
Lacks guilt
Eats nonfood
Accident prone
Nailbiting
Overeats
Overweight
Physical problems
Picking nose
Prefers older children
Sex problems
Smears bowel
Thumbsucking – 6 years
Too neat
Alcohol, drug
Wets self
Wets bed
Whining
Wishes to be opposite sex
Other problems

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Appendix 2

DEVELOPMENTAL PSYCHOPATHOLOGY CHECK LIST FOR CHILDREN

(A) DEVELOPMENTAL HISTORY	Yes	No
1. Did the mother, before, during or just after childbirth suffer from any problems like illness or difficult labour	0	1
2. Did the child have any serious illness soon after birth (If yes, specify)	0	1
3. Has the child had epilepsy, head injury, infections or any other serious illness? (If yes, specify.)	0	1
4 Has the child any problems in seeing? (If yes, describe.)	0	1
5. Has the child any problems in hearing? (If yes, describe.)	0	1
6 Between the ages of 1 and 3, could the child walk, climb, throw a ball? (If not, mark as present.)	0	1
7. Could the child by the age of 3, cut paper, thread beads. (If not, mark as present.)	0	1
8 Between the ages of 1 and 3, could the child speak in small sentences? (If not, mark as present.)	0	1
9. Could the child between the age of 1 and 3 years show appropriate emotional expression in relation to parents and others and did he/she enjoy playing with other children (If not, mark as present)	0	1

10.	Could the child between the age of 3 and 5 years, feed, wash and dress him/herself? (If not, mark as present.)	0	1

(B) DEVELOPMENTAL PROBLEMS

Currently or in the past, has there been a problem:

11.	of dropping things, falling or tripping frequently	0	1
12	for brief period when the child cried continuously to the extent of holding breath, become stiff, and turning blue in the face	0	1
13.	of making odd or funny, repeated movements of the face, body, arms and legs.	0	1
14.	in pronouncing words clearly (for example: 'Labbit' for 'Rabbit')	0	1
15.	in speaking, as stammering or stuttering.	0	1

Currently, does the child have the problems of:

16	not talking at all and remaining mute, despite knowing how to speak, in some situations and to some people.	0	1
17.	repeating the words spoken by others exactly in the manner they were heard, without appearing to understand the meaning.	0	1
18.	appearing to understand what is being said but seemingly not being able to answer	0	1
19.	of not being able to understand what is being spoken.	0	1
20.	appearing to understand and knowing how to speak, but speaking in a manner which other people find difficult to understand, and refusing to use gestures to convey his/her needs.	0	1
21.	not being able to relate to people.	0	1
22.	not being able to play with other children.	0	1
23.	feeding such as overeating, undereating, food fads or fussy eating habits, and eating non-edible things such as mud (If present, specify)	0	1
24.	wetting clothes or bed from a very early age.	0	1
25.	resuming wetting of the clothes or bed, after being dry earlier on.	0	1

26.	of soiling of the clothes with stools, or has constipation. (If present, specify.)	0	1
27	sleeping such as sleep-walking, sleep-talking, teeth-grinding, nightmares, etc. (If present, specify.)	0	1
28.	masturbating or any other sexual problems (which are indulged in public).	0	1

(C) PSYCHOPATHOLOGY

(The items below are marked as being present *only* when they occur *often or most of the time* but not when they occur sometimes)

Does the child have the problems of:

29.	poor attention	0	1
30	distractability—(if the child is doing a task and someone enters the room, or he hears a sound, does he easily get distracted by this).	0	1
31.	inability to sit in a place, and always moving around.	0	1
32	acting without thinking, like while crossing the road not looking out for the traffic.	0	1
33.	stubbornness	0	1
34	disobedience.	0	1
35	often interrupting others' games, talk; being disruptive while playing, or breaking/throwing things frequently.	0	1
36.	quarrelsomeness and fighting	0	1
37	aggression as seen by hitting, biting and pinching others (with/without provocation).	0	1
38.	getting very angry, crying a lot, rolling on the ground and continuing to be so for a long time, when his/her demands are not met.	0	1
39.	going to school and coming back on time, but actually does not attend the school.	0	1
40	indulging in lying and cheating	0	1
41.	refusing to go to school and staying back home for a duration of weeks or months.	0	1
42.	poor school performance.	0	1
43.	reading difficulty.	0	1
44.	difficulty in writing.	0	1

45.	difficulty in arithmetic.	0	1
46.	forgetfulness or poor memory	0	1
47.	day-dreaming.	0	1
48.	being very quiet and reserved (withdrawn).	0	1
49.	talking very little even with family members.	0	1
50.	worrying	0	1
51.	anxiousness and nervousness	0	1
52	shyness and timidity.	0	1
53.	fear of animals/people/situations.	0	1
54.	clinging	0	1
55.	crying easily.	0	1
56.	going on doing a particular thing over and over again, such as washing hands, or repeatedly saying certain numbers, or expressing that certain thoughts come to his/her mind repeatedly to the extent that they interfere with his/her daily activities	0	1
57.	complaining of dizziness or giddiness	0	1
58.	complaining of aches and pains	0	1
59.	complaining of/or appearing to be always tired.	0	1
60.	complaining of stomachache.	0	1
61.	fainting spells.	0	1
62.	attacks of jerky movements and unconsciousness (fits, conversions to be differentiated from epilepsy by a clinician).	0	1
63.	complaining of pulling sensation of the limbs	0	1
64.	chronic physical illness. (Specify, if present.)	0	1
65.	physical handicaps. (Specify, if present.)	0	1

Currently or in the past, has there been a problem of:

(The items below are to be marked as present *even* it has occurred *more than once in the past or present*)

66.	hearing voices and seeing things when no one was around.	0	1
67.	maintaining postures, being stiff, over long periods of time. (If present, describe)	0	1
68.	saying that he/she was a great person, or a bad person, or that he/she was being harmed by other people without real basis for such beliefs	0	1

69	talking and laughing to self.	0	1
70.	very poor appetite, sometimes leading to loss of weight.	0	1
71.	poor sleep/disturbed sleep.	0	1
72.	wetting and soiling during illness and was unaware of it	0	1
73	loss of interest in play and daily activities.	0	1
74.	moving and responding unusually slowly.	0	1
75.	being depressed, sad and dull	0	1
76.	talking much more or faster than he/she normally used to.	0	1
77	being irritable	0	1
78.	being unusually cheerful and happy (Others, if any.)	0	1

(D) PSYCHOSOCIAL FACTORS

(The items below are to be marked as present, whether in the past or present.)

Family history of:

79.	anyone having mental illness.	0	1
80.	anyone taking alcohol excessively	0	1
81.	anyone having epilepsy.	0	1
82	anyone having problems in reading, writing or arithmetic.	0	1
83	anyone having bed-wetting.	0	1
84.	anyone having speech problems	0	1
85	anyone being very dull or mentally retarded.	0	1
86.	Have there been any precipitating events at the time of onset of the problems. (Specify, if present)	0	1

Interaction in the Family

Is there any evidence of:

87	problems with parents. (If present, describe.)	0	1
88	sibling rivalry (jealousy of brothers and sisters).	0	1
89	marital disharmony (parents fight a lot).	0	1
90.	punitiveness Parents frequently resort to hitting, beating or punishing the child.	0	1

91	overexpectations- Parents expect from the child beyond his abilities, especially in school performance.	0	1
92.	overinvolvement Parents are involved with all the child's activities to the extent that he/she does not do anything on his/her own.	0	1
93.	overindulgence: Parents meet all the demands of the child, whether reasonable or not.	0	1
94.	indifference: Parents are not bothered about the child's physical or psychological needs.	0	1
95.	inconsistent disciplining: Parents do not agree about the way to discipline the child.	0	1
96.	multiple caretaking: (The child is brought up by a number of adults in the family).	0	1
97	single parent. The child has been cared for by a single parent.	0	1
98.	any change of school, medium or specific subjects or teachers.	0	1
99	the child complaining of problems with teachers.	0	1
100	the child having problems in playing, mixing or socializing with other children.	0	1
101.	the child having problems such as poverty and other stressors, not covered in the above section (if present, specify).	0	1

(E) TEMPERAMENTAL PROFILE

Descriptions of some aspects of the child's nature or temperament are given, and each description has three options to choose from. Encircle the options which fits the child best If the description is not applicable, if may be mentioned, especially for younger children.

Temperamental dimensions:

(a) *Psychosocial:*

								Not applicable
102.	Easy to manage	mostly	0	somewhat	1	not at all	1	..
103.	Independent (can manage himself/herself)	mostly	0	somewhat	1	not at all	1	..

104.	Dependable	mostly	0	somewhat	1	not at all	1	.
105	Sensitive (to other peoples' needs, emotions)	mostly	0	somewhat	1	not at all	1	..
106.	Sensitive (only about oneself)	mostly	0	somewhat	1	not at all	1	..
107.	Trusting	mostly	0	somewhat	1	not at all	1	..
108.	Trustworthy	mostly	0	somewhat	1	not at all	1	.
109.	Moral (discriminates between good & bad, knows it's bad to hit others, steal, etc)	mostly	0	somewhat	1	not at all	1	.

(b) *Biosocial*

110.	Sleep pattern	moderate	0	too little	1	too much	1	..
111.	Appetite	moderate	0	too little	1	too much	1	
112.	Activity	moderate	0	too little	1	too much	1	.
113.	Emotionally	cheerful (stable)	0	angry tense (intense & variable)	1	dull (non reactive)	1	.
114	Persistence	good	0	variable	1	too little	1	..
115.	Sociability with family members	mostly	0	variable	1	not at all	1	.

116.	Sociability with others	mostly	0	variable	1	not at all	1	
117.	Aggressive (verbal)	not at all	0	mostly	1	somewhat	1	
118.	Aggressive (physical)	not at all	0	mostly	1	somewhat	1	

(F) SUPPORTIVE FACTORS FOR MANAGEMENT

119	Does the child have any helpful person at home/outside: Somebody to whom the child is attached to, who helps the child, takes him/her out, buys the child gifts? (If yes, describe.)	0	1
120.	Does the child have friends in the neighbourhood or school? (If yes, describe.)	0	1
121.	Does the child have interest in drawing, painting, games, music, etc? (If yes, describe)	0	1
122.	Does the child have any special talents? (If yes, describe.)	0	1
123	Is the child good at sports? (If present, describe)	0	1
124.	Is the child creative, can put together commonplace objects in a new fashion, or make objects with hands? (If present, describe.)	0	1
	Other observations, if any:		

SUMMARY

S. H

Appendix C

Ten Subscales of Child Behaviour Checklist

The CBCL items were grouped under ten subscales as follows:

I. Schizoid or Anxious

- Clings to adults
- Fears
- Fears school
- Hears things that aren't there
- Nightmares
- Anxious
- Sees things that aren't there
- Shy, timid

II. Depressed

- Lonely
- Cries much
- Harms self
- Fears own impulses
- Needs to be perfect

Feels unloved
Feels persecuted
Feels worthless
Nervous
Anxious
Feels guilty
Self-conscious
Sulks
Suspicious
Suicial talk
Sad
Worrying

III. Uncommunicative

Confused
Won't talk
Secretive
Self-conscious
Shy, timid
Stares blankly
Stubborn
Sad

IV. Obsessive-Compulsive

Obsessions
Confused
Daydreams
Twitches
Nightmares

Anxious
Overtired
Compulsions
Sleeps little
Stares blankly
Hoarding
Strange behaviour
Strange ideas
Walks, talks in sleep
Excess talk
Can't sleep

V. Somatic Complaints

Constipated
Dizziness
Overtired
Pains
Much sleep

VI. Social Withdrawal

Poor peer relations
Feels persecuted
Is teased
Likes to be alone
Unliked
Prefers young children
Slow moving
Withdrawn

VII. Hyperactive

- Acts too young
- Can't concentrate
- Hyperactive
- Confused
- Daydreams
- Destroys own things
- Impulsive
- Poor school work
- Clumsy
- Prefers young children
- Speech problems

VIII. Aggressive

- Argues
- Brags
- Cruel to others
- Demands attention
- Disobeys at home
- Disobeys at school
- Poor peer relations
- Jealous
- Fights
- Lies, cheats
- Unliked
- Attacks people
- Screams
- Shows off

- Stubborn
- Moody
- Sulks
- Swearing
- Excess talk
- Teases
- Temper tantrums
- Threatens
- Loud

IX. Delinquent

- Destroys own things
- Destroys others' things
- Disobeys at school
- Bad friends
- Lies, cheats
- Runs away
- Sets fires
- Steals at home
- Steals outside home
- Swearing
- Truant
- Vandalism

X. Other Problems

- Allergy
- Asthma
- Acts like opposite sex
- Encopresis

Cruel to animals
Doesn't eat well
Lacks guilt
Eats nonfood
Accident prone
Nailbiting
Overeats
Overweight
Physical problems
Picking nose
Prefers older children
Sex problems
Smears bowel
Thumbsucking
Too neat
Alcohol, drug
Wets self
Wets bed
Whining
Wishes to be opposite sex
Other problems

Author Index

1c Epidemiology—Clinic data based on case history (contd.)

Investigators	Year	Centre	Sample	Sex/Age Characteristics	Disturbances
8. Menon et al.	1980	-	-	-	Hysteria
9. Sharma, Bhat & Sengupta	1980	Varanasi	30	6–12 years 14 Males 16 Females	Hysteria Anxiety neurosis
10. Annaiah	1981	Bangalore	160	-	Hysteria Scholastic backwardness
11. Trivedi, Singh & Sinha	1982	Lucknow	40	-	Hysteria
12. Sekar et al.	1983	Bangalore	40	6–14 years 21 Males 19 Females	Behaviour disorder
13 ICMR Report	1984	*Multi-centre Study* Bangalore Lucknow Delhi Waltair	1835	1–16 years	Neuroses Psychoses Hysteria Epilepsy Mental retardation Behaviour disorder Emotional disorder Scholastic backwardness
14. Malhotra & Chaturvedi	1984	Chandigarh	727	0–15 years	Mental retardation Neuroses Hyperkinesis Behaviour disorder Psychoses

Appendix 2

DEVELOPMENTAL PSYCHOPATHOLOGY CHECK LIST FOR CHILDREN

(A) DEVELOPMENTAL HISTORY	Yes	No
1. Did the mother, before, during or just after childbirth suffer from any problems like illness or difficult labour.	0	1
2. Did the child have any serious illness soon after birth. (If yes, specify.)	0	1
3. Has the child had epilepsy, head injury, infections or any other serious illness? (If yes, specify.)	0	1
4. Has the child any problems in seeing? (If yes, describe.)	0	1
5. Has the child any problems in hearing? (If yes, describe.)	0	1
6. Between the ages of 1 and 3, could the child walk, climb, throw a ball? (If not, mark as present.)	0	1
7. Could the child by the age of 3, cut paper, thread beads. (If not, mark as present.)	0	1
8. Between the ages of 1 and 3, could the child speak in small sentences? (If not, mark as present.)	0	1
9. Could the child between the age of 1 and 3 years show appropriate emotional expression in relation to parents and others and did he/she enjoy playing with other children. (If not, mark as present.)	0	1

10.	Could the child between the age of 3 and 5 years, feed, wash and dress him/herself? (If not, mark as present.)	0	1

(B) DEVELOPMENTAL PROBLEMS

Currently or in the past, has there been a problem:

11.	of dropping things, falling or tripping frequently.	0	1
12.	for brief period when the child cried continuously to the extent of holding breath, become stiff, and turning blue in the face.	0	1
13.	of making odd or funny, repeated movements of the face, body, arms and legs.	0	1
14.	in pronouncing words clearly (for example: 'Labbit' for 'Rabbit').	0	1
15.	in speaking, as stammering or stuttering.	0	1

Currently, does the child have the problems of:

16.	not talking at all and remaining mute, despite knowing how to speak, in some situations and to some people.	0	1
17.	repeating the words spoken by others exactly in the manner they were heard, without appearing to understand the meaning.	0	1
18.	appearing to understand what is being said but seemingly not being able to answer.	0	1
19.	of not being able to understand what is being spoken.	0	1
20.	appearing to understand and knowing how to speak, but speaking in a manner which other people find difficult to understand, and refusing to use gestures to convey his/her needs.	0	1
21.	not being able to relate to people.	0	1
22.	not being able to play with other children.	0	1
23.	feeding such as overeating, undereating, food fads or fussy eating habits, and eating non-edible things such as mud. (If present, specify.)	0	1
24.	wetting clothes or bed from a very early age.	0	1
25.	resuming wetting of the clothes or bed, after being dry earlier on.	0	1

26.	of soiling of the clothes with stools, or has constipation. (If present, specify.)	0	1
27.	sleeping such as sleep-walking, sleep-talking, teeth-grinding, nightmares, etc. (If present, specify.)	0	1
28.	masturbating or any other sexual problems (which are indulged in public).	0	1

(C) PSYCHOPATHOLOGY

(The items below are marked as being present *only* when they occur *often or most of the time* but not when they occur sometimes)

Does the child have the problems of:

29.	poor attention	0	1
30.	distractability—(if the child is doing a task and someone enters the room, or he hears a sound, does he easily get distracted by this).	0	1
31.	inability to sit in a place, and always moving around.	0	1
32.	acting without thinking, like while crossing the road not looking out for the traffic.	0	1
33.	stubbornness.	0	1
34.	disobedience.	0	1
35.	often interrupting others' games, talk; being disruptive while playing, or breaking/throwing things frequently.	0	1
36.	quarrelsomeness and fighting.	0	1
37.	aggression as seen by hitting, biting and pinching others (with/without provocation).	0	1
38.	getting very angry, crying a lot, rolling on the ground and continuing to be so for a long time, when his/her demands are not met.	0	1
39.	going to school and coming back on time, but actually does not attend the school.	0	1
40.	indulging in lying and cheating.	0	1
41.	refusing to go to school and staying back home for a duration of weeks or months.	0	1
42.	poor school performance.	0	1
43.	reading difficulty.	0	1
44.	difficulty in writing.	0	1

45.	difficulty in arithmetic.	0	1
46.	forgetfulness or poor memory.	0	1
47.	day-dreaming.	0	1
48.	being very quiet and reserved (withdrawn).	0	1
49.	talking very little even with family members.	0	1
50.	worrying.	0	1
51.	anxiousness and nervousness	0	1
52.	shyness and timidity.	0	1
53.	fear of animals/people/situations.	0	1
54.	clinging.	0	1
55.	crying easily.	0	1
56.	going on doing a particular thing over and over again, such as washing hands, or repeatedly saying certain numbers, or expressing that certain thoughts come to his/her mind repeatedly to the extent that they interfere with his/her daily activites.	0	1
57.	complaining of dizziness or giddiness.	0	1
58.	complaining of aches and pains	0	1
59.	complaining of/or appearing to be always tired.	0	1
60.	complaining of stomachache.	0	1
61.	fainting spells.	0	1
62.	attacks of jerky movements and unconsciousness (fits, conversions to be differentiated from epilepsy by a clinician).	0	1
63.	complaining of pulling sensation of the limbs.	0	1
64.	chronic physical illness. (Specify, if present.)	0	1
65.	physical handicaps. (Specify, if present.)	0	1

Currently or in the past, has there been a problem of:

(The items below are to be marked as present *even* it has occurred *more than once in the past or present*).

66.	hearing voices and seeing things when no one was around.	0	1
67.	maintaining postures, being stiff, over long periods of time. (If present, describe.)	0	1
68.	saying that he/she was a great person, or a bad person, or that he/she was being harmed by other people without real basis for such beliefs.	0	1

69.	talking and laughing to self.	0	1
70.	very poor appetite, sometimes leading to loss of weight.	0	1
71.	poor sleep/disturbed sleep.	0	1
72.	wetting and soiling during illness and was unaware of it.	0	1
73.	loss of interest in play and daily activities.	0	1
74.	moving and responding unusually slowly.	0	1
75.	being depressed, sad and dull.	0	1
76.	talking much more or faster than he/she normally used to.	0	1
77.	being irritable.	0	1
78.	being unusually cheerful and happy. (Others, if any.)	0	1

(D) PSYCHOSOCIAL FACTORS

(The items below are to be marked as present, whether in the past or present)

Family history of:

Grandparents have Kleptomania

79	anyone having mental illness	0	1
80.	anyone taking alcohol excessively.	0	1
81.	anyone having epilepsy.	0	1
82.	anyone having problems in reading, writing or arithmetic.	0	1
83.	anyone having bed-wetting	0	1
84.	anyone having speech problems.	0	1
85.	anyone being very dull or mentally retarded.	0	1
86.	Have there been any precipitating events at the time of onset of the problems. (Specify, if present)	0	1

Interaction in the Family

Is there any evidence of:

87.	problems with parents. (If present, describe.)	0	1
88.	sibling rivalry (jealousy of brothers and sisters).	0	1
89.	marital disharmony (parents fight a lot).	0	1
90.	punitiveness· Parents frequently resort to hitting, beating or punishing the child.	0	1

91.	overexpectations. Parents expect from the child beyond his abilities, especially in school performance.	0	1
92.	overinvolvement: Parents are involved with all the child's activities to the extent that he/she does not do anything on his/her own.	0	1
93.	overindulgence: Parents meet all the demands of the child, whether reasonable or not.	0	1
94.	indifference: Parents are not bothered about the child's physical or psychological needs.	0	1
95.	inconsistent disciplining: Parents do not agree about the way to discipline the child.	0	1
96.	multiple caretaking: (The child is brought up by a number of adults in the family).	0	1
97.	single parent: The child has been cared for by a single parent.	0	1
98.	any change of school, medium or specific subjects or teachers.	0	1
99.	the child complaining of problems with teachers.	0	1
100.	the child having problems in playing, mixing or socializing with other children.	0	1
101.	the child having problems such as poverty and other stressors, not covered in the above section (if present, specify).	0	1

(E) TEMPERAMENTAL PROFILE

Descriptions of some aspects of the child's nature or temperament are given, and each description has three options to choose from. Encircle the options which fits the child best. If the description is not applicable, if may be mentioned, especially for younger children.

Temperamental dimensions:

(a) *Psychosocial:*

								Not applicable
102.	Easy to manage	mostly	0	somewhat	1	not at all	1	..
103.	Independent (can manage himself/herself)	mostly	0	somewhat	1	not at all	1	..
104.	Dependable	mostly	0	somewhat	1	not at all	1	..
105.	Sensitive (to other peoples' needs, emotions)	mostly	0	somewhat	1	not at all	1	..
106.	Sensitive (only about oneself)	mostly	0	somewhat	1	not at all	1	..
107.	Trusting	mostly	0	somewhat	1	not at all	1	..
108	Trustworthy	mostly	0	somewhat	1	not at all	1	..
109.	Moral (discriminates between good & bad, knows it's bad to hit others, steal, etc.)	mostly	0	somewhat	1	not at all	1	..

(b) *Biosocial*

110.	Sleep pattern	moderate	0	too little	1	too much	1	..
111.	Appetite	moderate	0	too little	1	too much	1	..
112.	Activity	moderate	0	too little	1	too much	1	..
113.	Emotionally	cheerful (stable)	0	angry/tense (intense & variable)	1	dull (non reactive)	1	..
114.	Persistence	good	0	variable	1	too little	1	..
115.	Sociability with family members	mostly	0	variable	1	not at all	1	..

116.	Sociability with others	mostly	0	variable	1	not at all	1	..
117.	Aggressive (verbal)	not at all	0	mostly	1	somewhat	1	.
118	Aggressive (physical)	not at all	0	mostly	1	somewhat	1	

(F) SUPPORTIVE FACTORS FOR MANAGEMENT

119.	Does the child have any helpful person at home/outside· Somebody to whom the child is attached to, who helps the child, takes him/her out, buys the child gifts? (If yes, describe)	0	1
120.	Does the child have friends in the neighbourhood or school? (If yes, describe.)	0	1
121.	Does the child have interest in drawing, painting, games, music, etc? (If yes, describe)	0	1
122.	Does the child have any special talents? (If yes, describe.)	0	1
123.	Is the child good at sports? (If present, describe.)	0	1
124.	Is the child creative, can put together commonplace objects in a new fashion, or make objects with hands? (If present, describe.) Other observations, if any.	0	1

SUMMARY

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Appendix - I

Schedule For Assessment Of Behavioural Problems In Children

(For collecting information from Parents and Teachers)

Dr. D. A. Ashok
Dr. S. Ramaa
Dr. H. M Balachandra

Printed by :
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7. Whether he had run away from home at least twice while living with parents or parental surrogates? yes-no

8. Whether he often truant (absent) from school? yes-no

9. Whether these symptoms started before ten years or after ten years. yes/no

V *Depression*

1. Does your child look excessively or continually unhappy? yes/no

2. Does he report of low opinion about himself (self-depreciation)? yes/no

3. Whether he has lost appetite? yes/no

4. Whether his sleep is disturbed? yes/no

5. Does he look lethargic and dull? yes/no

6 Does he report of guilt feeling very often? yes/no

7. Does he weep with little or no provocation? yes/no

8. Whether any time he had expressed suicidal ideas? yes/no

9. Are there any genuine reasons for him to feel sad? (like separation, bereavement, failure, etc) yes/no

10 Does the child report of his own depressed mood? yes/no

Schedule For Assessment Of Behavioural Problems In Children

(For collecting information from Parents and Teachers)

Dr. D. A. Ashok
Dr. S. Ramaa
Dr. H. M. Balachandra

Guidelines for Administering the Schedule

Considerable percentage of children exhibit scholastic backwardness in schools. There are various causes for that. In some children scholastic backward ness may be due to learning disabilities or below average inteleetual functioning- In some other cases it may be due to totally remediable causes such as physical health problems or behaviour problems. Understanding the causes helps in providing valuable suggestions for a modification in the system of education according to the needs of such children.

School teachers and the parents are very important sources to collect valuable data about the child in question and they should participate in this programme with a sense of moral responsibility. They should be well appraised of the useful outcome of this effort Observing following disciplines will yield best results in this endeavour.

1. As far as possible the parents and the teachers should be contacted during their free time out

of their routine day-to-day work and when they are in reeeptive mood.

2. They should not be burdened with exhaustive interview in one sitting,

3 Shouid be polite in interrogating with parents and teachers and be lovable to children.

4. As far as possible the parents should be interro gated in simple and eolloquial language.

5. The schedule/Inventory should be thoroughly studied and understood before administering it to the parents and teachers.

6. Should be aware of the questions to be asked to parents and the questions to be asked to teaehers.

7. Some information given by the teacher about a child has to be confirmed with parents and vice-versa.

8. Any doubts about highly technical points should be discussed with respective specialists.

9. Wherever necessary and possible the child's family doctor should be contacted to get more clear information of the child's health problem.

10. The probiems noticed omong the children shouid be confirmed with the specialists

11. The problems noticed among children should be kept confidential and should be disclosed only to the parents and concerned teachers,

6 Do you think the child is having sufficiant interest and motivation to learn ? yes/no

7. Does he have any seeing or hearing problem ? yes/no

8 Do you think the child is free from serious emotional problem ? yes/no

9. Do you think the child has sufficient social skills ? yes-no

10. Are there any signs of brain injury in the child yes-no

11. Do you think it is dlfficult to make the child learn inspite of individualized attention ? yes/no

12 Do you think day by day the child is having more and more academic problems ? yes/no

IV *Conduct Disorders*

1. Does he often bullies, threatens or intimidates others ? yes/no

2. Whether he has been crual to animals and or people ? yes/no

3 Whether he often initiates physlcal fights with others ? yes/no

4. Whether he had used a weapon that can cause serious physical harm to others (Fg. a bat, brick, broken bottle, knife) yes/no

5. Does he often steal at home ? yes/no

6 Does he often lies to obtain good or favour or to avoid obligation (the work that ought to be done ?) yes-no

engage in tasks that require sustained mental effort such as school work or home works ?
yes-no

8. Does he often get distracted by activities going on around (ex : Sound produced by vehicles. TV, classmates talking to each other) yes–no
9. Does he often forgetful of his daily activities ? yes–no
10. Whether any of the above symptoms were present before the age of seven years ? yes–no
11. Whether these symptoms are not related to drug, medical or neurological illness. (brain injury, brain fever, epilepsy) as per your best judgement ? yes-no
12. Whether the above symptoms clearly affect the child's social or academic functioning ? yes-no

III *Learning Disabilities*

1. Does the child have serious difficulty in any of the following areas of academic learning : spoken language/reading/writing/spelling/arithmetic ? (tick the areas of problem) yes-no
2. Do you think the child is average or above average in intelligence ? yes no
3. Does the child show Hyperactivity and Attention Deficit Disorder as indicated above. yes/no
4. Does the child attend school regularly yes/no
5. Does he get academic help at home ? either by family members or tutor ? yes/no

SECTION A

Preliminary data of the Pupil

Name of the pupil :
Name of the School :
Class and secti n :
Medium of instruction :
Sex :
Age :
Residential address of the pupil :

Father's name

Qualification :
Occupati n :
Income :

Mother's name

Qualification :
Occupation :
Income :

Socio–Economic status of the family

a) Low
b) Middle
c) High

Marital Status of parents :

a) Consanguinity 1) Non consanguineous
2) Consanguineous

3) First degree consanguinity
4) Second degree consanguinity
5) Third degree consanguinity

b) Couple living together/separated/Father or Mother not alive

Order of birth of the child in the family :

SECTION B

Instruction : If the following symptoms are present tick (✓) yes or no.

Behavioural problems

I *Mental Retardation*

1. At what age your child first achieved the following milestones of development.

Neck holding .....
Standing with support .....
Walking .....
Running .....
Speaking clearly .....

2. Whether the milestones development of your child was delayed or slower than other child of same age yes-no

3. Whether your child can eat food on his own ? yes-no
4. Whether your child can dress by himself yes-no
5. Whether your child can bathe, wash his face by himself ? yes-no
6. Whether your child can clean herself after going to toilet ?
7. How do you, rate your child's academic performance? Excellent/very good/Good/ Average Below average.

II *Attention Deficit Disorder (Hyper Activity)*

1. Does he always appear restless and switching from one activity to another unnecessarily ? yes-no
2. Does he often fidget with hands or feet or squirms seat ? yes-no
3. Does he be able to concentrate on a particular activity for longer duration (watching TV/ movies) yes-no
4. Does he have difficulty in playing or engaging in useful activities during leisure time quietly ? yes-no
5. Does he often have difficulty in waiting for his turn yes-no
6. Does he interrupt or intrude on others (Eg. buffs into conversations or game) yes-no
7. Does he often avoid/dislike or is reluctant to

4. Does he talk irrelevantly or lack of coherence in his speech ? yes–no
5. Does the child hold odd or distorted beliefs ? If yes : yes–no
6. Are these odd or distorted beliefs are unusual for his age, background and ability ? yes–no
7. Does he think that people are saying things about him behind his back ? yes–no
8. Does he feel that some one is following him all the times ? yes–no
9. Does he report of some power or force other than himself that control him, but these ideas are not shared by family members ? yes–no
10. Whether these above symptoms have developed after the age of six years ? yes–no

11. Whether the child becomes withdrawn from others and talking less with others ? yes, no
12. Whether he speaks relevantly and clearly ? yes/no

VI *Hyper Anxiety :*

1. Do you and others speak of the child as anxious and worried ? yes/no
2. Does he say he often has shakes in his hands ? yes/no
3. Does he sweat a lot, even when sitting quietly yes/no
4 Does he have difficulty in going to sleep ? yes/no
5. Does he often feel that he is afraid of something? yes no
6. Does he report of "thumping" of his heart ? (palpitation) yes/no
7. Does he worry a lot ? yes/no
8. Does he frequently visit the toilet ? yes/no

VII *Obsessive–Compulsive Disorder*

1. Does your child repeat certain things over and over again ? (Eg washing hands, cleaning toilet) yes/no
2. Is he pre–occupied with always doing things in a strict, orderly manner ? yes/no
3. Is he very rigid about day–to–day activities and habit ? yes/no
4. Does he say he checks over and over again

things he has already complecated ? (ex. checking the door lock) yes/no

5. Does he like to touch/count things over and over again ? yes/no
6. Does he look over pre occupied with his daily routines ? yes/no
7. Does he avoid walking on certain places or does he avoid certain routes ? yes/no
8. Does he report of any persistant irrational thoughts come to his mind ? yes/no

VIII *Phobic Disorder*

1. Does he report of particular fears ? yes/no
2. Does he avoid certain things or places because he knows they will make him feel uneasy, while others do not ? yes/no
3. Does he feel very uncomfortable if he is in contact with a particular animal, object, place, ect ? If yes name them : yes/no
4. Is he afraid of the dark ? yes/no
5. Does his reaction of fear interfere with his normal life ? yes/no
6. Does the child appear normal when he is away from the situation of his fearfulness ? yes/no

IX *Autism*

1. Whether there was delay in the development of spoken language only ? yes/no
2. Does he generally spend most of the time playing alone ? yes/no

3. Does he look at the persons eye while conversing with them ? yes/no
4. Does he exhibit any repetitive or stereotype movements of hands or fingers like flapping, twisting ? yes/no
5. Does he spontaneously greet or wish the relatives or friends ? yes/no
6. Does he play with his toys very unusually (ex. throwing a toy car like a ball or rattling it) yes/no
7. Whether the child has normal intelligence ? yes/no
8. Whether these symptoms are present since childhood ? yes/no
9. Whether this was not due to or following brain fever, epilepsy or medical illness ? yes/no
10. Whether he is able to recollect the time, date persons correctly ? yes/no
11. Whether these symptoms were not due to any other medical or neurological causes ? yes/no

X *Psychosis*

1. Whether your child has become unusually withdrawn and talking very much less ? yes/no
2. Whether he reports of seeing things or hearing which others do not ? yes-no
3. Whether the child behaves as if he is hearing or seeing something, which others do not ? yes-no